Opioid prescribing is a surrogate for inadequate pain management resources

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The registrar of the College of Physicians and Surgeons of Ontario stated in 2010 that "opioids are an important part of the modern arsenal for treating chronic non-cancer pain."[1] He noted that clear guidance on the prescribing of opioids was needed and that the National Opioid Use Guideline Group had led a project to develop the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*.[2] A synopsis of the guideline was published in *CMAJ,* the journal of the Canadian Medical Association,[3] and in *Canadian Family Physician*.[4,5]

The guideline notes that "not enough is known about the long-term benefits, risks, and side effects of opioid therapy; more research is needed in these areas."[2] In the limitations section, it is stated that the guideline "addresses only one modality for managing [chronic noncancer pain]—opioid therapy, and it does not discuss or provide guidance about other options."[2] Although opioid therapy can be an adjunct therapy for chronic noncancer pain, these other therapeutic options need to be implemented *before* resorting to opioids. We contend that opioid prescribing by family physicians and other specialists alike is a surrogate for inadequate pain management resources in our communities and is the culmination of 2 decades of "pharmaceuticalization" of the treatment of chronic pain with drugs coupled with unscrupulous marketing by the pharmaceutical industry.

Guidelines to promote the safe and effective use of opioids were needed given the frequency of opioid prescribing and the high doses at which they have been prescribed over the past 15 years.[6] In Canada, between January 1, 2006, and December 31, 2011, Ontario had the highest annual rate of high-dose oxycodone and fentanyl dispensing (756 tablets and 112 patches, respectively, per 1000 population), while Alberta's rate of high-dose morphine dispensing was the highest in Canada (347 units per 1000 population).[7] Quebec had the lowest rate of high-dose oxycodone and morphine dispensing (98 and 53 units, respectively, per 1000 population).[7] A large body of research documents the adverse consequences of opioid prescribing, including addiction and death,[8-14] while there is no compelling evidence that long-term opioid use imparts benefits that outweigh the risks.[15-21] Rates of opioid-related deaths in Ontario increased between 1991 and 2010, from 12.2 to 41.6 deaths per million, a rise of 242%, and by 2010, years of potential life lost attributable to opioid-related deaths (21 927 years) exceeded those attributable to alcohol use disorders (18 465 years) and pneumonia (18 987 years).[11] In the United States the rate of death from overdoses of prescription opioids more than quadrupled between 1999 and 2010.[14]

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Why are opioids overprescribed?

Are physicians who prescribe opioids derelict in their duty, uncaring, and ignorant? No. In our experience, family doctors express intense frustration with the current inability to prescribe appropriate treatment interventions for patients with chronic noncancer-related painful conditions. Are the patients they treat malingering or seeking "highs" from their prescription medications? Maybe a few, but certainly not most. Does addiction to opioids in itself create a terrible cycle of dependency and drug-use escalation, and require specific treatments? Yes. It is time to stop mandating and to start thinking about the *whys* of opioid prescribing.

Several forces have led physicians to prescribe opioids more often than clinically warranted.

Lack of psychological and social community resources. Most patients do not have access to assessment and treatment of the factors that cause or contribute to their pain—the services of such health care professionals as nurses, physiotherapists, occupational therapists, psychologists, and social workers are not covered or are minimally paid for by publicly funded outpatient health care systems in Canada. This issue is rarely discussed. Evidence-based pain therapy shows that multidisciplinary care, which includes the interventions of these professionals, can assist patients with chronic pain.[22-26] A holistic approach incorporating prevention, active treatment, rehabilitation, and community care is strongly advocated as mainstream treatment,[22-26] but this approach is hardly available for physicians in their day-to-day pain management. Burnham et al[22] note how difficult it is to offer multidisciplinary care with traditional office-based pain management in terms of

physician remuneration and assessment and treatment of psychosocial issues. Specific programmatic funding at the community level is required. A family doctor was instrumental in leading many of the efforts of the chronic pain program that these authors describe.

Pressure on physicians and the "pharmaceuticalization" of chronic pain treatment. There are strong pressures on physicians to prescribe opioids to treat chronic pain. Some of these are well intentioned, including physicians' desire to relieve suffering, and the perception—in the face of the described lack of other resources—that opioids are the most effective tools for this purpose.

The more insidious pressures come from pharmaceutical manufacturers. The involvement of drug companies in the perpetuation of opioid prescribing over the past 2 decades is well described. In 2007, Purdue Pharma pleaded guilty in US federal court to criminal charges that it had misled doctors and patients when it claimed, among other things, that OxyContin was less likely to be abused than traditional narcotics were. Purdue Pharma has not faced consequences in Canada, despite having made similar false claims in this country.[27] Attendance at medical conferences, contributions to physicians' clinics, and financial support of physician education[28] contribute to the billion-dollar opioid-prescribing industry. Financial support of organizations, including the Canadian Pain Society, the American Pain Society, and the American Academy of Pain Medicine, as well as patient advocacy groups, by opioid manufacturers can be viewed as marketing under the veil of philanthropy.

In addition, pressure sometimes comes from patients, particularly those already receiving opioids, many of whom are (knowingly or not) pharmacologically dependent. Patients might be unaware of what resources are available to them in the community or might have no access to them. Consequently, they believe their only recourse is opioids.

Institutional practices and organization. Hospitals contribute to the problem by discharging inpatients and emergency department visitors with opioid prescriptions that then need follow-up by family doctors and other physicians, who feel removed from the patient because they did not provide the initial prescription.[29]

"Pain clinics" offering such treatments as injection therapy, physiotherapy, and psychological and nursing care have been established, but the types of providers at these clinics are not standardized.[30] In Canada personnel can vary from a single family doctor with little postgraduate training, to a group of anesthetists who primarily administer injections or provide nerve blocks, to groups receiving remuneration from the very manufacturers who produce opioids.

How do we turn back the tide?

Several strategies are needed to reduce the prescribing of opioids and the attendant harms while improving the care of patients with chronic pain.

- Chronic pain costs more than cancer, heart disease, and HIV combined. Estimates place direct health care costs for Canada at more than $6 billion per year and productivity costs related to job loss and sick days at $37 billion per year.[31,32] Resources should be redistributed so that family physicians and other specialists can refer their patients to services or facilities that provide social work, psychology, physical therapy, occupational therapy, and ergonomic and exercise support. We believe that these services would be more likely to succeed within family medicine environments than in free-standing pain management facilities. Specific multidisciplinary programs have been demonstrated to improve International Classification of Functioning, Disability and Health outcomes in patients with back pain, fibromyalgia, and chronic pain[33]; facilitate return to work in patients with low back pain[34]; and increase self-efficacy and decrease total Fibromyalgia Impact Questionnaire scores and pain at 3 months and 1 year.[35]
- Physicians should work collaboratively with other health care professionals with expertise in pain management. This has begun to happen. Pharmacists, a new addition to some family practice teams in Ontario, can provide a unique perspective on opioids. In our experience, substantial dose reductions of opioids are possible through a combination of education, reevaluation of pain, and in-house social work intervention. While a trial dose reduction might show little or no difference in pain control, it is often accompanied by a lessening of the adverse effects of opioids that can dramatically affect quality of life.
- The pharmaceutical industry's influence on opioid prescribing is huge but insufficiently acknowledged. It has been recommended that Health Canada regulate the marketing of medications that might be harmfully misused, by such means as proactively monitoring advertising claims and banning certain practices (eg, physician office visits by company representatives, sponsoring of education and training of health care providers).[27]
- Prescription drug monitoring programs that are accessible to both pharmacists *and* prescribers could contribute to more appropriate opioid prescribing, as this would put more information in the hands of prescribers. They would then be better able to identify patients who might be addicted to or abusing medications and provide the support that those patients need to deal with their addictions (and to ensure that huge volumes of these drugs are not being put out into the community). The United States and

the United Kingdom have programs to curb opioid misuse (eg, prescription drug monitoring programs, the Food and Drug Administration's Risk Mitigation and Education Strategy, and the ePACT system, which allows authorized users to electronically access prescription data[36]). In November 2011 the Narcotics Safety and Awareness Act was implemented in Ontario. A key component of the act is the Narcotics Monitoring System (NMS), which captures prescriber, pharmacist, and patient information for all narcotics and other controlled drugs dispensed in Ontario. The NMS was created to provide provincial policy makers with the tools to identify potentially inappropriate prescribing of monitored drugs. A recent evaluation suggested that this program has been able to decrease inappropriate opioid prescription.[37] This occurred with the NMS giving information primarily to pharmacists. If the data were also available to prescribers, it would have an even greater, more beneficial effect, as it would avoid prescriptions ever being written in cases in which they are inappropriate. While this does not deal with the lack of available resources and other treatments for patients experiencing chronic painful conditions, it does address one aspect of the problem.

- More research is needed to characterize the patient populations that will benefit from long-term opioid treatment.
- More educational opportunities that integrate pain management principles into the many areas of medicine into which pain extends its reach—eg, rheumatology, neurology, orthopedic surgery, and cardiology—are needed in undergraduate and postgraduate medical education. Focusing teaching in specific pain-related blocks is helpful, but pain is far too common a symptom to restrict its teaching to a specific time in the curriculum.
- General guidelines for chronic noncancer pain management should be developed. This could play a key role in standardizing treatment and furthering the objective of promoting multidisciplinary treatment.

Conclusion

Physicians want to ethically and effectively treat their patients with chronic pain, but the barriers to high-quality care are great. The lack of psychological and social resources in our communities, as well as internal and external pressures upon physicians, negatively affect the treatment of these patients and contribute to excessive opioid prescription by well-meaning physicians, and addiction becomes an added patient and societal burden.[11]

A fundamental missing piece in the opioid puzzle is addressing how we have come to this juncture. While screening for our patients' addictive potential[2] and setting out contracts for opioid ingestion are important, addressing societal needs and the resources provided to help those with chronic noncancer pain is equally important. Physicians, their professional organizations, and medical colleges and associations should be advocating for better access to chronic pain resources if we are to reduce opioid prescribing and the harms that ensue. A new dialogue concerning the treatment of chronic pain is required. Rather than only disbursing disability payments and promulgating guidelines, it is time for medical health plans to put money up front and organize efficient and creative chronic pain interventions. Patients in pain deserve better, safer, and more comprehensive treatment.

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Competing interests

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